<u>Question 1:</u> How will ACOs be implemented in rural areas?

Based on media reports (e.g., the September 26, 2010, *Washington Post* article), urban hospitals view ACOs as a driver for consolidation. In rural areas, however, consolidation is not a practical alternative. As a general rule, rural communities strongly resist loss of local control; the loss of the local hospital is viewed as tantamount to a death sentence for most small communities.

There are real opportunities, however, for rural providers to form collaborative care networks, especially if there are opportunities for shared savings. The ACO model detailed in the Affordable Care Act, however, imposes barriers to rural participation in the program; including the 5,000 Medicare covered lives requirement and the disqualification of Critical Access Hospitals as ACO participants.

For example, most CAHs in Kansas serve counties whose populations include fewer than 1,000 Medicare beneficiaries. Thus, creating an ACO with 5,000 beneficiaries will require participation of providers and beneficiaries across several counties. This means participation by several hospitals–some PPS and some CAHs. Is there any reason an ACO could not include a CAH, provided the members agree among themselves how cost savings should be allocated?

Providers are understandably nervous about collaborative action, given the prohibitions of the antitrust laws and anti-referral statutes. We find little direction offered in the current DOJ/FTC Statements of Antitrust Enforcement Policy or HHS OIG advisory opinions with respect to such rural ACO collaboratives (what we refer to as "RACOs"). Do the agencies intend to issuance guidance regarding the proper boundaries for collaborative action among providers in a rural area?

We believe rural ACOs could be a vehicle for reducing costs and delivering quality care to beneficiaries with certain chronic or specialized conditions (e.g., diabetes, heart disease, COPD, orthopedics, cancer). We envision an ACO being assigned all Medicare beneficiaries within a given region with a particular diagnosis, as opposed to a disparate population of 5,000. This would require some tailoring of the ACO model to allow rural ACOs to assign each of its participants as the specialists in a particular type of care. Would the agencies be amenable to such an approach that focuses on chronic care and involves, essentially, market allocation?

<u>Question 2:</u> How will ACOs sustain the shared savings payment over time?

As we read the statute, the benchmark for determining shared savings will be based on a rolling, three-year average. Thus, it seems that, at some point, all the savings will be wrung out of the system. At that point, will there be a payment mechanism to replace the "shared savings" concept? Or, is this just a transitional program that will then phase out when the organizations reach maximum efficiency?